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**Subject:** HHCS Coordinated Care Response in Medicaid Program  
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Please find attached Heartland Human Care Services' Coordinated Care Response in Medicaid Programming.

Thank you for the allowing providers to comment.

Joe Antolin

Executive Director, Heartland Human Care Services, Inc.

# THE COORDINATED CARE PROGRAM KEY POLICY ISSUES

**June 2011**

The Medicaid reform law adopted by the Illinois General Assembly in 2011, P.A. 96-1501, mandates that 50 percent of all Illinois Medicaid recipients be in coordinated care by January 1, 2015. (Relevant language from this law is attached to this document.) While outlining a general sense of direction for the Medicaid program, the legislation leaves key operational issues to be determined by the Department of Healthcare and Family Services. This paper helps identify some of the issues and seeks public and stakeholder advice on how to implement coordinated care in Illinois. Initially we are inviting stakeholders to provide written comment in response to the following specific policy questions. Subsequently, we will hold public hearings to discuss the responses, focusing particularly on those areas where there is no consensus. Please note that "Medicaid" is used in this document to apply to all State comprehensive medical health programs, including the Children's Health Insurance Program and certain related state-funded programs, as enumerated in the legislation.

***Please submit your comments electronically to [hfs.webmaster@illinois.gov](mailto:hfs.webmaster@illinois.gov) no later than close of business, July 1. All comments will be posted on the Coordinated Care tab on the HFS website. We will subsequently announce hearings during the summer.***

Although the legislation requires at least 50% of all clients to be enrolled in coordination care by January 1, 2015, there are two important realities that will shape implementation of this policy and are useful to set the context for the issues in this paper:

- About 45% of our current enrollees live in Chicago, another 14% live in Kane, DuPage, Lake and Will counties, and another 10% in a handful of downstate urban counties. The remaining 30% of our clients are scattered over 87 rural counties. While we believe everyone should have coordinated care, it will be difficult to offer the same delivery systems in the 87 rural counties that we offer in the more densely populated areas. Therefore, it will be practical to focus initially on the higher density areas – possibly enrolling materially more than 50% of the clients in these areas to meet the 50% statewide target.
- The Department will begin enrolling newly eligible Medicaid clients under the Affordable Care Act in the fall of 2013. **This means we will have to establish coordinated delivery systems in place prior to the fall of 2013.**

Below are the specific questions on which we are seeking comments. Comments do not need to address all questions, but as much as possible, all comments should respond to specific questions. Since many of the issues are interconnected, there may be multiple ways of arranging responses. Issues for comment are organized as follows:

- How comprehensive must coordinated care be?
- What should be appropriate measures for health care outcomes and evidence-based practices?
- To what extent should electronic information capabilities be required?
- What are the risk-based payment arrangements that should be included in care coordination?
- What structural characteristics should be required for new models of coordinated care?
- What should be the requirements for client assignment?
- How should consumer rights and continuity of care be protected?
- What is your organization’s preliminary anticipation of how it might participate in coordinated care?

### ***1. How comprehensive must coordinated care be?***

The legislation is clear that to meet the definition of coordinated care, an entity must provide or arrange for the “majority of care”, including a patient-centered medical home with a primary care physician, referrals from the primary care physician, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, and when appropriate, rehabilitation and long-term care services. The law also requires arrangements where the State pays for performance related to health care outcomes, the use of evidence-based practices, the use of electronic medical records, and the appropriate exchange of health information electronically.

This comprehensive definition does not contemplate coordinated care coverage for specific diseases, such as management of asthma or diabetes. It does not preclude, however, organizations that offer comprehensive services or care management tailored to people with specific diseases or

conditions working with other entities serving a broader population. In addition, medical homes will be required components of coordinated care, but by themselves will not be sufficient to meet the requirement for accepting responsibility over all services.

Coordinated care in Illinois is contemplated to include a wider range of potential arrangements than traditional, fully capitated managed care. Coordinated care entities could be organized by hospitals, physician groups, FQHCs or social service organizations. While the Department would like to test these new models, we need to determine the current level of interest and capacity to offer these comprehensive, risk-based services through the Medicaid Program.

### Questions for Comment

- a) Do you think that coordinated care should require contracts with specific entities that arrange care for the entire range of services available to a client via Medicaid, across multiple settings and providers? Are there any alternatives you would recommend for consideration?

***Response: Yes. Coordinated Care Organizations' (CCO) networks need to be able to provide a spectrum of services integrating primary health care with mental health and behavioral health. Either prevention and wellness services should be required services incorporated into all of these CCOs and reimbursable especially for those with episodic mental disorders or who live in supportive housing.***

***In the alternative, the Agency also should be contracting for community based wellness and prevention services directly with organizations capable of gaining trust among community members. Wellness and prevention services include the comprehensive array of services that address behavior, education and prevention. This is a practical way to reduce long term health costs. This is especially true for participants and families with special needs, such as those who: are legal immigrants (refugees, asylees, victims of trafficking), have limited English-speaking abilities, are functionally illiterate, are experiencing homelessness, are teen parents, cycle in and out of employment, or suffer from depression and anxiety related disorders***

- b) Must all of these elements be required in any entity accepting a contract, or just some elements? Might these change over time, i.e. start with a base set of requirements and gradually increase over time?

***Response: A floor needs to be set on the core requirements of the service mix. This floor could shift to include additional services depending on the population a given CCO is focused on serving. Doing a phase in of the service package may make sense to better manage ramp up.***

- c) Medical homes are generally considered the hub for coordinated care. How should the existence of a "medical home" be operationalized? Would existence of a medical home require NCQA certification? Would all primary care physicians be required to be in practices that meet these requirements? What requirements are essential for every practice?

Presumably it would be possible to increase requirements over time. What progression would make most sense?

***Response: The hub of a CCO needs to be considered as the “health home model” which recognizes comprehensive needs for the model to be successful.***

***While primary care plays a central role, a variety of services beyond direct medical intervention are needed for a CCO to be effective. Illinoisans who currently do not access preventative primary health, often have case managers, social workers, or other community workers who they are in contact with regularly and have built a rapport. It is these entities who need to be included as Care Coordinators in the broad health homes model or who need to be able to connect to cases and bill directly for services. For example, a refugee who was resettled by a specific agency, receives education, employment, housing, and mental health services through that agency, will often not understand or feel comfortable visiting the assigned Primary Care Physician. However, if the agency acts as care coordinator or a community based partner to a care coordinator, any early signs of physical health concerns can be addressed and linked with a medical center within the CCO. The coordination team together works with the person to insure appropriate treatment at all levels, thus alleviating a later visit to the Emergency Room or waiting until surgery is necessary.***

***Clearly coordinating the health home is also important. The care coordinator will likely need to shift throughout the course of a participant’s life in the network. For example, if entry into the CCO comes through an agency, who provides counseling services and interacts with the participant monthly. As a result of the regular contact and trust build, the participant reveals a breast lump was discovered. The care coordinator assists the client in accessing the primary care within the CCO, at that time it may be needed for the care coordinator to become a PCP and the linkage, hand off, and ongoing communication needs to be included in quality measures for the state.***

***It is a good idea to have accredited agencies providing the work to ensure a high level of quality services is provided. However, NCQA should not be the only certification; for example other behavioral health accreditations need to be recognized as well, such as CARF.***

- d) How explicit should requirements be about how an entity achieves coordinated care? For instance, should the care coordination entity be required to assign an integrator or care coordinator to each enrollee?

***Response: Generally speaking, parameters should be set that ensure a basic level of adequate care can be found in all CCOs. There still needs to be some level of flexibility to allow for unique relationships and participant populations. Such latitude will better allow for innovation.***

***Assigning a care coordinator is key to ensuring that someone with the network – not***

***necessarily the hub organization – is accountable for a given patient. Who that integrator is should be flexible. The integrator necessarily should be connecting each participant to primary, mental, and behavioral health resources. For example, the care coordinator must be linguistically appropriate for the variety of limited-English speakers around the State of Illinois, which could necessitate a community agency taking the lead for that particular person or population, within the CCO network.***

- e) Where, if at all, should HFS provide some kind of umbrella coverage for entities, e.g. negotiate a master pharmaceutical contract that would be available to all coordinated care entities?

***Response: It would be helpful for the state to provide umbrella coverage, with alternative options allowable in cases where that coverage does not suit special needs populations.***

- f) What incentives could be offered to enlist a wide range of providers, in key service areas, to join coordinated care networks?

***Response: Incentive payments should be offered for meeting health benchmarks not available outside of a CCO.***

***Training & Technical assistance.***

***In order to ensure that the hardest to serve participants are reached, some amount of outreach will be required. Agencies should be rewarded for serving the high-utilizers and hardest to reach in an effort to assuage “cherry-picking” as outlined in Question 6.***

***Participants who are new to the system will access CCOs through community agencies or health care providers they trust. As a result, there must be a “no wrong door” approach to eligibility. In order to encourage this, incentives should be provided to agencies with flexible eligibility, who are willing to take all participants.***

## **2. What should be appropriate measures for health care outcomes and evidence-based practices?**

The law requires payment based on outcomes and use of evidence-based practice. How should this be operationalized? There is an emerging body of research and analysis on outcomes and evidence-based practice. Presumably the State will establish a set of measures and standards and create incentives relative to those measures. The difficulty will be balancing the number of measures that could possibly go into defining high quality care with the need to keep the incentive packages administratively manageable. Whatever measures are used should be chosen from nationally accepted measures (e.g. HEDIS, CMS Quality Measures, etc.).

### **Questions for Comment**

- a) What are the most important quality measures that should be considered?

**Response: For otherwise lower volume users or healthy families, wellness and prevention targets: smoking cessation, HIV prevention, obesity reduction, reduced violence, reduced anxiety and depression symptoms, children's immunizations among the measures.**

- b) Is there one set of measures that should be applied to all coordinated care or might there be different measures for different kinds of clients--for instance, children versus adults or disabled versus non-disabled?

**Response: HFS should not use a one-size fits all set of measurements for CCOs. Different sub-populations within Medicaid need different standards. For example, someone that is dual diagnosed cannot have the same set of measures – with the same benchmarks – as someone with a lower need for acute care.**

**In addition best practices and promising approaches to wellness and prevention require utilizing established – but new to HFS – public health, CDC and research based metrics and to develop new ones to ensure efficient and effective delivery is contributing to savings (as opposed to discouragement of services)**

- c) How should the Department think about client risk adjustment in order to level the playing field as providers deal with patients across a wide range of situations?

**Response: Rates need to reflect the population being served and the associated costs for serving that population. HFS could establish categories of risk with accompanying rates. These rates could be applied across an entire CCO if that CCO specializes in a given population, or it could be set according to estimations on the percentage of a given population being served from month to month. E.g. If a CCO has about 15% of its participant population individuals that have multiple chronic conditions, 15% of their bundled payment would be set at the higher rate set for that population.**

**For wellness and prevention and public health interventions the rates needs to support broad based education and incremental improvements understanding that continuity will lead to changes in health risky behavior over time reducing the adverse health outcomes**

**Thought should be given to higher rates to deliver services to otherwise isolated communities (geography or culture and language) or to areas where Illinois is seeking to reduce racial and ethnic health outcome disparities.**

- d) What kind of guidance is available concerning the number of measures that would make sense, especially since coordinated care covers a broad spectrum of care?

**Response: Whatever the number of measures, they should be outcomes or outputs that are reasonable related to outcomes and not just process measures. The number of measures should be focused and the fewest to ensure quality should be the focus. If there are too many measures, the administrative infrastructure to collect and report is a significant add on away from rates intended to promote health. Each measure should be**

**tested as does this represent a meaningful outcome or inform outcome determinations versus is this a measure of interest. Only the former should be used.**

- e) What percentage of total payment should be specifically tied to quality measures?

**Response: the percentage of incentive payments should increase over time as the CCO is established and its quality healthcare delivery coupled with prevention and wellness impact is taking hold.**

**It is important that the quality measure not incent poor practices for financial reasons, these would include delay in services or more creative ways to avoid appropriate but costly procedures**

**If it is an incentive and the recipient is a non profit, it should represent net revenue to reinvest, i.e, more than the core funding needed to provide sustainable services.**

**From a financial risk side, a base guaranteed rate is needed to ensure basic costs are covered and that there is stability in the payment system at acceptable quality standards to discourage profit making mills**

- f) How can the Department most effectively work with other payors to adopt a coordinated set of quality measures so that providers would have a clear set of measures toward which to work?

**Response: Utilize the significant market share of the State and Insurance to set the standards**

- g) How will we know when we have achieved care coordination, i.e. how should we measure success?

**Response: We need to measure and reward quality services, not simply quantitative or fiscal outcomes.**

**Indicators for measurement need to consist of a spectrum reflecting population served, services provided, geography, and other challenges which may vary and the health outcomes relative to the prior experience in a prior year with a similar population.**

### **3. To what extent should electronic information capabilities be required?**

The state and federal governments are strongly committed to the concept that all medical practice in the 21st century needs to operate in the context of an electronic health record that, in some degree, is connected to all other providers. But that is not the current situation. Even the progress taking place and anticipated in response to the incentive payments created by ARRA will not result in universal electronic coverage and information exchange in the near term. Accordingly, it would



be unrealistic to require these capabilities initially, even though we expect material progress from the current situation by 2013.

#### Questions for Comment

- a) What type of communication related to the clinical care of a Medicaid client should be required among providers until electronic medical records and health exchanges become ubiquitous?

**Response: The expectations should be well defined in rules and contracts consistent with achieving better outcomes and within the framework administratively that is reasonably support by the rates.**

**If there are supplemental agreements with community based organizations the expectations need to be well defined and properly compensated.**

- b) Should the Department offer bonuses for investments in EHR systems, above the substantial incentives from ARRA?

**Response: Not necessarily but only to fill identified gaps**

- c) If additional incentives were going to be added for being electronically enabled, that would inevitably mean less reimbursement somewhere else. How important are incentives above and beyond the ARRA incentives to induce electronic connectivity? What trade-offs would be appropriate to support such incentives? (For instance, should the amount of money available for outcome incentives be reduced to increase these incentives? Or should there be a lower base rate with specific incentives for increasing connectivity?)

**Response: Since outcome data and better integrated care are goals, such incentives may be a necessary step to effectively use the system.**

- d) On what time frame should we expect all practices to be electronically enabled? How would we operationalize the requirements? Is tying them to the official "meaningful use" requirements sufficient?

#### **4. What are the risk-based payment arrangements that should be included in care coordination?**

The Medicaid reform law is clear that risk is a key component of coordinated care. Capitated payments paid to traditional managed care organizations are obvious; however, the law is not specific as to whether coordinated care entities need to assume 100% of the risk and other risk-based arrangements might be considered. The Department is mindful that provision of efficient, high quality care is most determined by the people closest to providing that care, and providing appropriate incentives is the best way to fully engage them in focusing on outcomes. We understand, however, for many providers this is a challenge to current operations.

#### Questions for Comment

- a) How much risk should be necessary to qualify as risk-based?

- b) Could "risk-based arrangements" include models with only up-side risk, such as pay-for-performance or a shared savings model? But if it's only up-side risk, is there any "skin in the game", without something to be lost by bad performance?

***Response: There needs to be negative repercussions for a failure to meet base-level benchmarks, but those negatives should not compromise the care of an individual. The system needs to allow for warnings and opportunities to make adjustments so operations can learn and improve.***

- c) If initially included, over what time frame should these arrangements be replaced with the acceptance of down-side risk?
- d) What should be the relative size of potential payments conditioned on whether a provider is accepting full risk as compared to a shared savings model?

***Response: Commenting on proposed models would be more useful.***

- e) In the case of either a capitated or a shared-savings model, what should be the maximum amount of "bonus"? Stated differently, what is the minimum Medical Loss Ratio for a provider?
- f) Who should be at risk? Is it sufficient that the coordinated care entity accepts risk, or must there be a model for sharing that risk with direct providers?

***Response: There needs to be some form of shared risk among the direct providers, but how that risk is structured could be left to the hub organization to determine. This could allow for testing different forms of shared risk.***

- g) How should risk adjustment be included in the model? Conversely, how should "stop loss" or "reinsurance" programs be incorporated?
- h) How can the state assure that capitated rates or other risk-based payments are not used to limit appropriate care or serve as a disincentive to diagnose and treat complex (i.e. expensive) conditions?

***Response: Strict parameters must be set that state that a CCO cannot collect up-side risk payments if there is a failure to meet standards for serving those with complex conditions or for delay or failure to respond with appropriate necessary procedures.***

##### ***5. What structural characteristics should be required for new models of coordinated care?***

Assuming the Department enters into contracts with entities other than managed care entities, the Department must have criteria to determine if the entity has the capability to successfully coordinate care for Medicaid clients.

Questions for Comment

- a) Should Medicaid lead or follow the market? Should we contract only with entities with operational, proven models or should we be willing to be an entity's first or first significant client?

**Response: Lead**

- b) What is the financial base necessary to provide sufficient stability in the face of risk-based arrangements? How should the determination of "minimal financial base" be different for one and two-sided risk arrangements? Should Department of Insurance certification be required?
- c) Should there be a minimum number of enrollees required in an entity for it to be financially stable and worth the administrative resources necessary to accommodate it and monitor it? Should that amount differ by types of client? Can it be different for entities taking one-sided as opposed to two-sided risk?

**Response: Potential CCOs should be required to provide a business plan with audited financials and projections within the CCO and stating their assumptions related to utilization and risk and how they can/will be financially stable.**

- d) What primary care or access to specialty care should be required? How extensive should be the network of providers to be able to offer access to a full range of care?

**Response: All CCOs should be providing access to primary health, mental, behavioral and preventative health, as well as specialized services. The full spectrum of services should be included because community services are not sufficient to cover the need and will likely be reducing as funding for human services gets cut.**

**While this may be population dependent, we must err on the side of inclusiveness, to reduce and not perpetuate the existing health disparities that exist, especially for communities of color and impoverished areas, and those who have been left out of traditional HMO systems (underemployed, those with substance abuse or mental health issues, etc.)**

**Access needs to be extended to services such as physical therapy, behavioral health, comparable to Medicare programs, which provide more comprehensive access to coverage.**

- e) Should special arrangement be made to accommodate entities that want to provide coordinated care to particularly expensive or otherwise difficult clients?

**Response: Yes. One way of managing risk is to allow for specialized CCOs that can provide needed services to a "difficult" population. This category of CCO could have a different set of standards & rates due to the inherently complex nature of their participant population.**

## **6. What should be the requirements for client assignment?**

Care coordination entities must serve an identified population that is enrolled in Medicaid; they cannot exclude any member of the population for which they are responsible – or individually “cherry-pick” their own enrollees. The current Illinois Health Connect program (Medicaid’s Primary Care Case Management program) requires that all Medicaid clients be enrolled with a specific primary care provider. Under the new policy, Medicaid clients may be required to enroll in a specific care coordination program, with enrollee protections to assure quality and access. Steps should be taken to maximize the proportion of clients who voluntarily enroll (self-assign), but when clients do not choose, how should they be assigned?

### Questions for Comment

- a) The Medicaid reform law requires that clients have choices of plans, as do federal regulations. Would it make sense to limit the choices of clients by underlying medical conditions? (For instance, can all clients with specified behavioral health issues be required to choose among a different set of providers than clients not so identified?) Is this practical?

**Response: Yes too many choices is overwhelming to the consume and opens the door to predatory practices. There should be a limited number of quality choices vetted by the Department.**

- b) How much should the Department stratify choice areas by geography? Considered alternatively, would a provider need to have network coverage throughout a major area, such as Chicago? Or could a coordinated care entity limit its offerings to a particular neighborhood?

**Response: The scope of the catchment area of a CCO should relate to the characteristics of the population being served. E.g. Those experiencing homelessness or depression may have less mobility than those closer to 133% FPL.**

- c) Can entities limit the eligible population they serve, and how narrowly can they limit their population? (Can providers, for instance, limit themselves to AABD or TANF populations, or even more narrowly, such as children with complex medical needs or individuals with serious mental illness)?

**Response: Limiting the eligible population should not occur unless in very rare occurrences the population is higher need or there is a specialty that is required.. CCOs should not be allowed to cherry-pick, but network providers within the CCO can be more targeted.**

**In the case of exceptions, a rationale argument needs to be developed to prove that there is a need to focus in a given population. Those limiting their participant population will still need to show they can provide the base level of comprehensive services and meet all other generally applicable targets.**

- d) On what basis should assignment of clients who have not self-assigned be made in the first year?

**Response: None. Mandatory assignment could be a disaster as was done in the past by Medicaid and HMOs. There needs to be education and clients should be exercising choice and volunteering (just as anyone does when they have choice at an employer).**

- e) One approach would be to make auto-assignment to capacity in proportion to the self-assigning choices. Another approach would be to allow providers to bid on slots, with lower rates getting a larger proportion of the auto-assignees. What are the strengths and weaknesses of these approaches? Are there other approaches?

Ensuring language and cultural competency

- f) Over time, the auto-assignment bases could change: one approach would be to make auto-assignment in relation to outcomes. Cost could also be a factor. How long a period should be allowed before switching to a more experienced-based formula?

**Response: In later years auto assignment because of outcomes and risks makes sense and that allows HFS to provide adequate notice allowing the client to make a choice or by inaction effectively assent to the auto selection.**

- g) Whether for self or auto-assignment, should there be a client lock-in period? If so, for how long? What safety mechanism should exist for clients where stringent enforcement of the lock-in would be detrimental?

**Response: Preferably no significant lock-in period. Realistically, there may need to be open enrollment periods.**

**It is important that participants who have special circumstances or changes can change their assignment later. Examples include language and cultural competence of providers, a change in geography, and if a CCO does not provide crucial services needed. A change for cause and appeal system must be clearly communicated.**

**If there is a lock-in period, the communication of auto-assignment needs to be communicated clearly and more than once prior to lock in. For example, if a refugee family is resettled, a letter would need to be translated and case managers assist with navigating the system, there needs to be time allowed for change because many client need special assistance.**

- h) If the Department sponsors some demonstration projects to launch care coordination, how can enrollment be mandated?

**Response: By well defined criteria and significant fiscal or health related reason to justify the extraordinary action of a mandate**

- i) How should care be coordinated for Medicaid recipients who are also enrolled in the Medicare program?

## **7. How should consumer rights and continuity of care be protected?**

Over the last 20 years, the managed care model has matured significantly. It has moved from an emphasis on disapproving care to an emphasis on actually coordinating care. This emphasis has been reinforced by the more rigorous review of managed care entities (such as NCQA assurances)

and, at the current time, there is good reason to believe that the degree of quality assurance and oversight in the managed care market is greater than what exists in the fee-for-service market, in which every patient is required to fend for herself with little oversight or assistance. As part of maintaining, and building on, these improvements, however, it is appropriate to assure that clients have reasonably defined ways of expressing their satisfaction with the care they are receiving and have issues addressed, whether they are enrolled in traditional managed care entities or some alternative coordinated care model.

In addition, after January 1, 2014, the Health Benefits Exchange will become operational under the Affordable Care Act. Newly eligible Medicaid clients in Illinois would likely be offered coordinated care; other clients over the 133% Federal Poverty Level threshold would be shopping for private health insurance, with tax subsidies. The Department is committed to making sure that clients' can continue to use the same providers, even if their source of funding is changed due to shifting income.

#### Questions for Comment

a) How do we assume continuity of care as entities come and go or change contractual status? (This issue could be particularly acute if HFS "leads" the market by allowing contracting with entities for whom Medicaid is their only coordinated care contact.)

b) Although not strictly a coordinated care issue, how can continuity of care be maintained for low income clients across Medicaid and other subsidized insurance programs--such as will be provided by the Health Benefits Exchange under the ACA? In that respect, how important to continuity is a Basic Health Plan (a provision in the ACA that allows States to create a plan for clients with incomes between Medicaid eligibility and 200% of the Federal Poverty Level)?

**Response: Continuity of care and of coverage is very important especially for lower income workers who cycle between employment period or who have multiple employers.**

c) Should plans be required to offer plans in both Medicaid and the Exchange, with essentially transparent movement from one to the other if client income or circumstances change?

**Response: An excellent approach – absolutely.**

d) What rights, if any, should the client have to continue a medical home relationship in changing circumstances?

**Response: Those that within budget realities offer the best health outcomes, and are geographically or culturally/linguistically appropriate.**

e) What mechanisms should be required to obtain client information on an ongoing basis about plan quality? What appeal rights might be necessary?

**Response: Appeal rights that review the circumstances and are not a process error appeal system but provide for a full hearing (de novo if need be). The system should have paramount the best health outcomes in mind for deciding the matters raised by the appealing client**

**8. What is your organization's preliminary anticipation of how it might participate in coordinated care?**

While this paper makes it clear that there are numerous policy issues that are open for discussion, it is our hope that the range of issues raised also makes it clear that the State is committed to testing new models in addition to traditional managed care. Recognizing that any intentions at this point are preliminary, it would be useful to get some sense of how various providers and provider groups are thinking they might participate in coordinated care.

Questions for comment:

- a) How would your organization participate in coordinated care? Entities might be considering responses such as contracting with coordinated care entities or forming Community Care Networks or Accountable Care Organizations (ACOs) that could directly accept risk. If you aren't sure how your organization would participate, what would be some of the factors impacting your choice?

***Response: We anticipate not leading an ACO, but becoming members and creating partnerships with multiple CCOs, as we provide a broad range of specialized services, counseling, case management and home visits, public health approaches, and .***

***Cost of infrastructure, upstart, including data management, and reimbursement of basic costs (such as case management and administrative oversight) could be prohibitive if not included in allowable, reimbursable expenses. We recommend utilizing ARRA stimulus funds to ensure multiple agencies and especially community case organizations have the capacity to provide services that are necessary for the whole system to work (prevention, wellness, case management, etc.)***

- b) Do you have some model in mind that you think would work to meet the terms of the law and also work well for you and the patients you serve? If so, please share it.
- c) Is your organization considering developing a Medicare ACO? Do you see opportunities for entities like ACOs in the private market? How do you see yourself involved in either Medicare or other forms of ACOs?
- d) If your organization is considering participating in Medicaid coordinated care in some way beyond contracting with coordinated care entities, do you think you will be ready to do so by mid-2013? If not, when?

***Response: Many of our services related to prevention and wellness need to be added to reimbursable schedules to allow full participation as a Medicaid provider. There needs to be a revisiting of what is medically necessary and paid for in the system.***

- e) For how many Medicaid clients could you anticipate taking coordinated care responsibility? Is there a particular group of clients for whom you believe your organization is particularly suited or for whom it has developed particular expertise?

***Response: The expertise of HHCS is in our breadth and ability to connect education and services to participants in the community and in their homes. Our wellness and health impacts approaches are linked to employment, housing, benefit access, anti violence programming and are neither a traditional medical model nor readily siloed. We also have specific expertise in HIV prevention, alternative to violence, counseling, services to victims of crime-sexual assault, domestic violence and trafficking; wellness, supportive housing wrap-around services (including case management to reduce depression and anxiety), behavioral modification for successful employment; working with clients who have mental illness that can be in the community and well managed but requires LCSWs and case managers to assist, such as mood disorders, and medical case management for HIV or Diabetes. We work with newcomer populations (refugees, immigrants, asylees) and have linguistic and cultural competency. Most of these approaches also help to reduce racial and ethnic health disparities tied to poverty***

***Much work is going into the discussion of integrating behavioral and mental health with the primary health. However, if at-risk populations and all the services being discuss are not included, implemented, monitored, and enforced the primary care system will break down and health care costs will continue to rise due to quantity of emergency room visits, lack of care following major surgery (mental health, in home, etc.), long term chronic diseases (heart disease, liver disease, diabetes, lung disease, asthma) that are caused or exacerbated by behavioral health (smoking, eating, substance abuse, mood disorders).***

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There are undoubtedly areas for comment that we have failed to include or specific questions that we omitted within the general areas we selected. Please feel free to offer comments beyond the specific questions posed, but try to make your comments as specific as possible. The purpose of this paper is to receive your input as HFS moves from the broad policy outlines provided by the law to policies necessary to implement the law in a fair and beneficial manner.

Once again, please submit comments to [hfs.webmaster@illinois.gov](mailto:hfs.webmaster@illinois.gov) **by close of business, Friday, July 1.** If you have specific questions, please pose them to the same address and we will get back to you. You should watch the Coordinated Care tab in the HFS website as we will post updates and, as relevant, clarifications and answers to broadly relevant questions as we have them prior to July 1. Thank you very much for your input. We want to make this process as open and participative as possible.